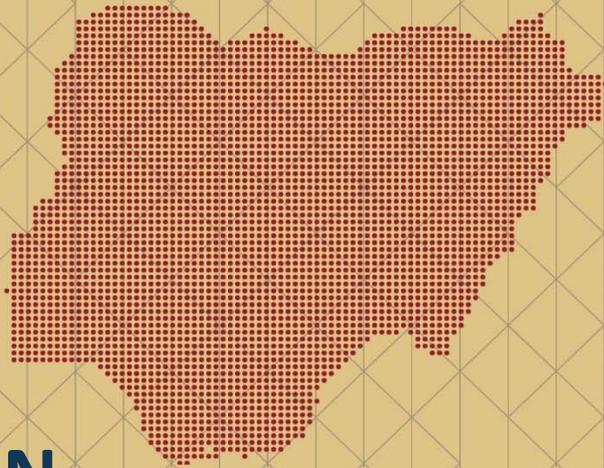


# NIGERIA

## COUNTRY CONSULTATION REPORT



### Key Findings

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## GLOSSARY OF ABBREVIATION AND ACRONYMS

ACS	- African Collaboration for Health Financing Solution Project
ANC	- Antenatal Care
BHCPF	- Basic Health Care Provision Fund
BMGF	- Bill & Melinda Gates Foundation
CRF	- Consolidated Revenue Fund
CSOS	- Civil Society Organizations
DFID	- Department for International Development
DRF	- Drug Revolving Fund
ECOWAS	- Economic Community of West African States
EMONC	- Emergency Obstetric and Neonatal Care
ERGP	- Economic Recovery and Growth Plan
FCT	- Federal Capital Territory
FMBNP	- Federal Ministry of Budget and National Planning
FMOF	- Federal Ministry of Finance
FMOH	- Federal Ministry of Health
HC3	- Health Communication Capacity Collaborative Project
HCF	- Health Care Finance
HERFON	- Health Reform Foundation of Nigeria
HSRC	- Health Sector Reform Coalition
ITWG	- Investment Technical Working Group
MOE	- Ministry of Education
NGOs	- Nongovernmental Organization
NHA	- National Hospital Abuja
NHIS	- National Health Insurance Scheme
NPHCDA	- National Primary Health Care Development Agency
PHC	- Primary Health Care
PHCUOR	- Bringing Primary Health Care under one Roof
R4D	- Results for Development
SIDA	- Swedish International Development Cooperation Agency
SOMLPfor	- Saving One Million Lives, Program for Results
UHC	- Universal Health Coverage
UNFPA	- United Nations Population Fund
UNICEF	- United Nations Children Fund
USAID	- United States Agency for International Development
WAHO	- West African Health Organization
WB	- World Bank
WHO	- World Health Organization

## EXECUTIVE SUMMARY

Nigeria operates a three-tier healthcare system which consists of primary, secondary and tertiary levels. This system aligns with the country's political governance structure of local, state and federal governments respectively. All three tiers of government have concurrent responsibilities for the provision of quality healthcare to the country's citizens. The federal government is responsible for overall coordination of tertiary healthcare services, while the state governments manage the secondary-level healthcare services and the local governments focus mainly on primary healthcare services. The latter is regulated by the federal government through the National Primary Health Care Development Agency (NPHCDA).

There has been slow progress in Nigeria towards equitable coverage, access to quality health services and efficient health spending. This may be attributed to challenges in implementing health financing policies. Over the years, low funding and public spending on Nigeria health system have led to poor health care infrastructure, inequitable distribution of the health workforce, inadequate performance and service delivery, and weak referral systems and accountability mechanisms.

The African Collaborative for Health Financing Solutions Project (ACS), a 5-year USAID-funded project, led by Results for Development (R4D) in partnership with the Duke Global Health Innovation Center and Feed the Children, are working in sub Saharan Africa to advance Universal Health Coverage (UHC) by addressing challenges and promoting solutions that further the implementation of health financing policies and programs. As part of a broader consultation phase in five countries and at the global and regional levels, ACS recently conducted a stakeholder consultation in Nigeria to determine the level of understanding and progress on UHC; identify stakeholder collaborations; identify barriers towards achieving UHC; and gather recommendations from key stakeholder groups that will inform ACS program design towards supporting and advancing UHC.

The study revealed that most stakeholder groups in the health sector in Nigeria approve the strengthening of primary healthcare (PHC) as a topmost priority for advancing UHC. The stakeholders also perceived the progress of implementation of the UHC policies and strategies to be generally slow and canvassed the need for meaningful engagement of community members, civil society, and other non-state actors.

In addition, the study revealed stakeholders' awareness of existing policies and initiatives which, if effectively implemented, have the potential to significantly accelerate the movement towards UHC. These initiatives include the National Health Insurance Scheme Act, 2009; Primary Health Care Under One Roof 2011; Saving One Million Lives Program for Results 2012; the Basic Health Care Provision Fund as enshrined in the National Health Act 2014; the Nigeria Health Financing Policy and Strategy, 2017; and the Economic Recovery and Growth Plan (ERGP) 2017.

According to findings from the study, several collaborative opportunities exist within the key ministries that drive UHC. These are the Federal Ministry of Health, the National Primary HealthCare Development Agency and the National Health Insurance Scheme. Other opportunities involve wider stakeholders such as the legislators, media, civil society and the private sector.

The stated aim of these collaborative efforts is to promote understanding, build capacity for implementation, create advocacy for increased financing and ensure accountability in implementation. In order to capitalize on these opportunities, those interviewed mentioned there would be need to revive and strengthen the National UHC Committee that brings all relevant stakeholders from public and private sectors, civil society and development partners on UHC dialogue; work closely with Legislative Network on UHC and the Nigerian Governors' Forum to enhance legislation and resource allocation for UHC. The Legislative Network on UHC and the Nigerian Governors' Forum are good platforms that could enhance support for UHC at national and sub-national levels.

However, some challenges and barriers exist against the quick advancement of UHC objectives in Nigeria. Key barriers mentioned by stakeholders include inadequate funding; inefficient allocation and use of resources; inadequate political will and commitment to health; weak governance and enforcement; poor involvement of non-state actors; poor human resources capacity, skill and management; lack of evidence generation and competing national priorities.

As part of their recommendations, stakeholders said they would like to prioritize the following key areas regarding UHC: increase in domestic resource mobilization; obtain legislative buy-in; leverage technology; improve institutional structures; build human capacity and better coordinated on or funding and support to federal and state programs.

Other specific recommendations were made on the three pillars of the ACS approach as follows:

**Collaboration:**

- a. Strengthen the links between the public and private sectors to enable the private sector to become more integrated within the various levels of the health system.
- b. Embed ACS into appropriate existing structures and networks, instead of trying to reinvent the wheel.
- c. Strengthen existing UHC networks to include the private sector, community members, and other interest groups to expand the dialogue and activities to accelerate UHC.

**Knowledge sharing and Learning:**

- a. Identify innovations across states and share best practices.
- b. Support evidence generation for UHC baseline at state level.

**Accountability:**

- a. Support activities around legislative and policy advocacy.
- b. Support and strengthen governance and finance systems.

In summary, stakeholders recommended that government should maximally focus on achieving the implementation of its policies, ensure adequate funding for UHC initiatives and adopt ICT in all its interventions. The donors and development partners were encouraged to provide flexible funding for learning, sharing, and innovation while civil society was expected to create innovations that would generate demand for UHC and engage more closely with community members to ensure accountability.

## 1. BACKGROUND:

### ○ NIGERIA'S HEALTH SYSTEM AND POLICY FRAMEWORK AROUND UHC

Nigeria is Africa's most populous country with a projected population (2017) of 182,867,631 based on a growth rate of 3.5%, with more than half of its population under 30 years of age. The country has 36 states and a federal capital territory (FCT) and operates a three-tier healthcare system consisting of primary, secondary and tertiary levels. This system also aligns with Nigeria's political governance structure of local, state and federal government respectively, with all three tiers of Government having differential but concurrent responsibility for the provision of quality healthcare to the citizens. The federal government is responsible for the overall coordination of tertiary healthcare services, while the state government manages the secondary-level healthcare services and the Local Government focuses on primary healthcare services. The latter is regulated by the federal government through the National Primary Healthcare Development Agency (NPHCDA). The primary healthcare system, which is the first point of care remains the weakest despite several policy commitments by the federal government to strengthen this level of healthcare delivery, having recognized PHC as pivotal to the achievement of Universal Health Coverage (UHC) by 2030. The National Council on Health (NCH) is the highest policymaking body in Nigeria on matters relating to health. Although the NCH platform is utilized to promote synergy and coordination of the different stakeholders in the health system, there is still the challenge of non-compliance by states due to the semi-autonomy enjoyed by them.

### ○ Policy framework supporting UHC

Over the past few years, stakeholders in Nigeria have made significant efforts towards advancing the UHC agenda, with the goal of achieving UHC by 2030. A presidential summit on UHC, involving various health sector stakeholders in Nigeria, was held in March 2014. A key output of the summit was a set of recommended actions, prescribed for the Nigerian government actors at various levels, for the improvement of financial and physical access as well as the quality of health services towards attaining UHC. This summit was to garner the highest level of political commitment (from the president, governors, local government chairmen, parliamentarians and other political stakeholders) to UHC.

The federal government has developed a set of health policies and strategies aimed at improving availability, accessibility, affordability, and quality of health services. These policies and strategies include Primary Health Care Under One Roof (PHCUOR) 2011; Saving One Million Lives (SMOL) 2012; the Basic Health Care Provision Fund as enshrined in the National Health Act 2014; National Health Policy 2016; Nigeria Health Financing Policy and Strategy (NHFP&S) 2017; and Economic Recovery and Growth Plan (ERGP) 2017.

Furthermore, the recently approved Health Financing Policy and Strategy 2017 aims to provide evidence-based guidance to federal, state and local governments, and other stakeholders in the Nigerian health system on how to provide an equitable and efficient health financing system that will guarantee achievement of UHC 2030. The objectives of the National Health Financing Policy and Strategy over the next five years are to:

- a. Improve health coverage by 30% to 50 million Nigerians;
- b. Reduce out-of-pocket expenditure as a percentage of the total health expenditure by 20%;
- c. Increase the percentage of general government's health expenditure by 5%;
- d. Improve primary healthcare expenditure by 20%;
- e. Increase preventative services spending by 15%;
- f. Ensure performance-based financing for NHIS and 50% of health protection schemes; and,
- g. Establish and strengthen accountable, transparent and sustainable healthcare financing systems at the Federal, State and Local Government levels.

The National Health Insurance Scheme (NHIS), one of the agencies under the Federal Ministry of Health (FMOH) was established to provide financial risk protection to Nigerians in accessing healthcare. The NHIS has developed programs to cover formal and informal sectors as well as vulnerable groups. Although the NHIS was established in 2009, it covers less than 5% of the population, most of whom are federal public sector employees. Due to the heterogeneous nature of the Nigerian state governments, with 36 semi-autonomous states and the Federal Capital Territory, having a central level health insurance scheme remains a challenge for attaining UHC until it is fully decentralized. There are current efforts by NHIS to decentralize and get state governments to establish state community health insurance schemes.

The National Primary Health Care Development Agency (NPHCDA), also one of the agencies under FMOH, is responsible for ensuring physical access to quality primary health care delivery especially at the state and local levels. The NPHCDA is currently implementing the *Bringing Primary Health Care Under One Roof (PHCUOR)* policy initiative approved by NCH in 2011, to integrate the management of primary healthcare into one governance structure and improve PHC performance. This PHCOUR policy initiative is reinforced with the political commitment of the current administration to revitalize 10,000 primary health facilities and make at least one primary health facility fully functional in each of the 744 wards across the country.

The Basic Health Care Provision Fund (BHCPF) enshrined in the National Health Act 2014 makes provision for additional funding to improve PHC services in Nigeria. FMOH has two key agencies, NHIS and NPHCDA, both having a joint responsibility in the administration of the BHCPF to provide key services in the basic minimum package of health services (BMPHS) as shown in table 1 below.

Table 1: Basic Minimum Package of Health Services

CLINICAL SERVICES	FOCUSED METHOD OF DELIVERY	INTERVENTION 01	INTERVENTION 02	INTERVENTION 03
<b>1. Maternal Health Services</b>				
<b>Antenatal Care (ANC)</b>	Minimum of 4 ANC visits	Malaria prevention with Intermittent Preventive Treatment (IPT): Sulphadoxine and Pyrimethamine; PMTCT (HIV/AIDS)	ITN, Folic Acid, Iron, Doctor must see at one of the first two visits visit	Ultrasound Scan (Max 3), Urinalysis, Haemoglobin, HIV, Hep B
<b>Labour &amp; Delivery Care</b>	Skilled Birth Attendants (SBAs) at all facilities	Partograph Monitoring	Episiotomy & Repair	Post-Natal care including mother and baby care, from first visit within 48 hours of delivery to second visit 6 weeks post-partum.
<b>Emergency Obstetric and Neonatal Care (EmONC)</b>	Basic & Comprehensive Emergency Obstetric and Neonatal Care	IV/IM Antibiotics, IV/IM Oxytocics, IV/IM Anticonvulsants, Manual removal of placenta, Assisted vaginal delivery, Removal of conception retained products; Essential Newborn care	All seven BEmONC functions plus Emergency Caesarean Section, Blood Transfusion	
<b>Clinically-indicated Elective Caesarean Section, Instrument delivery (forceps delivery, vacuum extraction)</b>	Chorio-amnionitis, Gestational Diabetes, Hypertension, Multiple pregnancy, Placenta Praevia, Pre-eclampsia and Eclampsia, IUGR			
<b>2. Prevention and Treatment of Non-Communicable Diseases (NCDs)</b>				
<b>Hypertension</b>	Primary Care Blood Pressure Monitoring; Secondary Prevention Education	Lifestyle interventions for preventing Hypertension	Advice on Blood pressure control in people with pressure higher than 140/90 mmHg	

Source: Nigeria Investment Case; 2017 draft

### ○ Health Expenditure

Nigeria is yet to meet the 2001 Abuja declaration made by African heads of government to allocate at least 15% of its national budget to health. The budgetary allocation to the health sector at the federal level in the last decade has averaged 6% (See Annex 1 for further health expenditure statistics).

Nigeria's health system has been characterized by low public spending; for instance in 2014, the per capita health expenditure by the government was \$29.55 billion, compared to a total per capita spending of \$117.00 (NHA, 2014). The out-of-pocket expenditure accounted for over 65% of total health expenditures, well above the WHO (2010) indicator for tracking progress towards achieving UHC that recommends not more than 30-40%. These low levels of public expenditure on health and an NHIS

coverage that is largely formal-sector driven and voluntary enrolment demonstrate very slow progress towards achieving universal health coverage in Nigeria.

One significant hurdle has been around policy implementation and enforcement of enabling legislation. Since the existing policies and legislation were developed at the federal government level, there's need for replication and implementation of similar policies and legislation at the state and local government levels in order to accelerate the progress towards attaining UHC.

## 2. CONSULTATION FINDINGS

The African Collaborative for Health Financing Solutions (ACS) consultation team visited Nigeria from 20 to 29 November 2017 and from 17 to 21 December 2017 to conduct interviews with diverse health stakeholders involved in UHC (See Annex 2 for stakeholder respondent categories). The intended outcome of this consultation was to establish the following:

- Knowledge of UHC, and priorities around UHC and healthcare financing in Nigeria;
- Stakeholder dynamics, collaboration initiatives and platforms /mechanisms for dialogue on UHC;
- UHC barriers and challenges;
- Innovative solutions to accelerate implementation of UHC related policies and programs; and
- Potential priority areas in which the ACS project can support Nigeria towards progressing UHC.

Twenty-five interviews were conducted with national stakeholders and another five interviews were conducted at the sub-national level (Bauchi State). The findings from the interviews are listed below.

### 2.1. BACKGROUND ON UHC

#### ○ Stakeholders' Definition of Universal Health Coverage

The majority of the stakeholders defined UHC in terms of affordability, accessibility and equitable access to healthcare regardless of background or status. Most of the stakeholders interviewed stated that UHC meant "access to quality and affordable healthcare" for everyone devoid of financial hardship. Key UHC elements such as access to quality care, expansion of coverage of health services and financial protection resonated in most of the stakeholders' definitions. CSO respondents defined UHC more in terms of "accessibility" of healthcare services for the poor and vulnerable groups, while technicians and public sector implementers emphasized coverage and quality of care. Some CSOs indicated that there were various forms of UHC definitions by different stakeholders which made the concept ambiguous and confusing.

The similarities in the definitions provided by the stakeholders depict an understanding of the UHC concept. However, some public and private sector implementers did not feel that there was, in fact, a common understanding of what UHC means. For instance, a civil society stakeholder mentioned that "*no one size fits all for what UHC means, it is defined within the context of where each nation finds itself and the resources available.*" And a public sector implementer stated that the "*tenets of UHC have not been sufficiently defined for us to understand and look at certain aspects, i.e., macro-economic conditions that will affect UHC.*"

In addition to defining UHC, the civil society respondents were specifically asked about the level of community knowledge of the concept of UHC. Four CSO respondents stated that the knowledge of UHC at the community level was very poor. Some of the CSO respondents also cited poor knowledge of UHC amongst public officers at the sub-national level. For example, one respondent stated that "*even civil servants at state and local government levels who should have some knowledge, lack knowledge of what UHC is.*" Some respondents attributed the poor knowledge of UHC at community level to community

members' lack of knowledge of their rights and limited access to information and poor communication systems within the health care system, which create lack of accountability for the government to the people. CSOs were of the view that there needed to be more awareness campaigns, especially at the community level.

**Box 1: Excerpts of stakeholders' definitions of UHC**

*“UHC means the capacity of the ordinary man at the bottom of the social pyramid to be able to access healthcare without totally destabilizing his/her finances at the detriment of his/her family's health”- CSO*

*“Health reaches the doors of each Nigerian as captured in SDG goals”- **Public sector implementer***

*“Accessibility, affordability of healthcare delivery services to all citizens wherever they are, irrespective of who they are, what they are and what they stand for”-**Private Sector Implementer***

*“UHC must be viewed as a tripod i.e. demand-side, supply-side and oversight/regulation...”**Development Partner***

○ **Priorities for Health Financing and UHC**

The majority of the stakeholders cited improving primary healthcare services as topmost priority for advancing UHC in Nigeria. Many stakeholder respondent groups such as civil society, public sector, researchers, development partners and politicians cited the current government's Initiative to revitalize 10,000 PHC facilities in each ward of the 774 local government areas in the country as evidence of the government's commitment towards UHC. However, some respondents also noted that the slow actualization of this initiative and many other policies is due to insufficient and unreliable funding of the health sector.

**Box 2: Priorities for Health Financing and UHC**

*“Top priority is to have PHC facilities functional – the PHC revitalization initiative is the current strategy being explored”- **Public Sector Technician***

*“2014 Health Act determined at least 1% of total government revenue should be allocated to health to provide the basic health package. It is a sad day to say this fund has not been implemented and we have not made progress”-**Politician***

*“Nigerian government has recommitted to achieving UHC using PHC over past three years, government has re-engineered efforts towards this, and WHO is aligned” - **Development Partner***

*“NHIS hasn't reached the community level and it is now trickling down to states. FFS and OOP for health fall on the common man in the rural communities”-**Faith-based Private Implementer***

The full implementation of the National Health Insurance Act and decentralization of the health insurance schemes was highlighted particularly by sub-national CSOs, public and private sector implementers as another priority area for advancing UHC. The respondents called for increased funding, coordination and expansion of the scheme to accommodate both formal and informal sectors, especially at the sub-national and local government levels. Stakeholders also mentioned the implementation of key provisions of the National Health Act and PHCOUR policy at the sub-national level as a priority to advance UHC.

Some private sector CSOs and development partners also mentioned the need to involve the organized private sector in decision-making at all levels of health care system as a way to improve funding and efficiency of the health sector. One respondent summed up these perspectives this way: *“Government*

*cannot do it alone; they need to involve the private sector*". Some private stakeholders spoke on the need to demonstrate strong political will in the full implementation of several public-private partnership guidelines and policies that have been developed in the past.

Civil society and development partner respondent groups indicated priorities such as the need to track flow of funds (budget transparency), educate stakeholders on topics, and involve CSOs as an important means to achieving the objective of improving health financing in the country. Development partner respondents further pointed to resource mobilization as a priority for advancing UHC in Nigeria. Public sector respondents stated that priorities are defined along the overall UHC priorities, which are: having full access to services, financial risk protection and having real top quality medical services.

#### ○ **Organizational activities related to UHC**

Some CSOs, development partners, private and public sector implementers said their work contributes towards advancing UHC. Each of the stakeholders interviewed was asked to highlight three of their organization's key activities that contribute to advancing UHC. From their responses, the top three priority activities that emerged are improving primary healthcare services, advocacy and championing policy development.

Most private and public-sector respondents highlighted service delivery as one of their priorities that directly contribute to UHC. Almost all CSO stakeholder groups mentioned "advocacy" as one of their priority areas of work. Advocacy activities mentioned particularly by CSOs, development partners, the private sector and individual activists suggest an involvement of various stakeholders at different levels in advocacy efforts. For example, most of the CSOs cited engagement in advocacy efforts to influence policy decisions of FMOH, Federal Ministry of Budget and National Planning (FMOB & NP) and parliamentarians to allocate at least 1% of the CRF to the National Health budget for the BHCPF, as provided for by the National Health Act, 2014. The FMOH implementers also mentioned advocacy engagement with their counterparts at the FMOB & NP to justify the need to include an allocation for the BHCF in the health budget. Another example of advocacy activities was the NHIS implementers' advocacy to the state government to buy into the NHIS and implement schemes at the sub-national and local levels.

Private sector and development partners also reported advocacy activities targeting full implementation of the PHCOUR, which is meant to improve PHC capacity to provide basic health care services at the local level. Evidence generation and use were also reported by stakeholders to be a critical part of their advocacy efforts. For example, several CSO respondents described how the generation and use of score cards and public expenditure reviews helped advance their advocacy work and resulted in one state government increasing budgetary allocations for health. In addition, most CSO activists noted priorities such as the need to track flow of funds (budget transparency), educate stakeholders on topics related to UHC, and involve CSOs as important means to achieving the objective of progressing health financing in country.

Some CSOs, public sector and development partners mentioned championing policy development and building capacity for policy implementation as another priority work area to advance UHC. These stakeholder groups are involved in supporting the states to replicate federal level policies, legislation and institutional frameworks and structures to facilitate the implementation of health programs that accelerate the progress towards attaining UHC. For example, a development partner respondent reported how his organization provided technical assistance to 12 states to develop legal frameworks and guidelines to operationalize the NHIS.

#### **Organizational multi-sectoral collaboration, learning and accountability efforts**

CSOs, public and private sector implementers and development partners reported different types of collaboration. The type of collaboration described across the groups ranged from joint funding and

participation in activities, to convening stakeholders' dialogues and coalitions. Some stakeholder groups such as CSOs, development partners and public sector implementers cited working with legislators either at the federal or state levels on issues related to UHC such as advocacy on PHCUOR or capacity building efforts at state level to implement state health insurance schemes.

Various stakeholder groups such as private and public sectors, CSOs and implementing partners lead or support activities related to learning and knowledge management for UHC. These stakeholder groups reported being involved in promoting UHC knowledge among citizens. Some of the activities related to citizen learning include conducting outreach activities to educate on available health services and how these services could be accessed. Other stakeholder groups such as researchers and the private sector reported involvement in evidence generation and research to support health financing. Some commonly used channels for dissemination and learning reported by respondents included mainstream media, organizational newsletters, on-line blogs, research papers, publications and various stakeholder platforms. Some CSOs, public-sector and development partner respondents particularly cited platforms such as the citizen learning platforms, Joint Learning Network for UHC at national and sub-national levels, Health Sector Reform Coalition and the Legislative Network for UHC as places where stakeholders convene for learning and advocacy to justify investments in health.

Some stakeholder respondents, particularly CSOs and development partners, stated that their accountability efforts entail monitoring progress of health status and health budgets and expenditures. The civil society respondents stated that they are particularly involved in promoting citizen participation in policy dialogue and empowering them to demand better health services. Some CSOs also reported engaging the media in their accountability efforts to publish investigative stories on public health issues as a way to trigger government response.

## **2.2 STAKEHOLDER DYNAMICS**

### **○ Primary Collaborators On UHC Activities**

Some respondents described broad and varied groups of collaborators within and across their stakeholder groups which primarily include development partners, civil society, individual activists, and governmental entities at both federal and local levels. Development partners, CSOs and politicians cited the FMOH, NHIS and NPHCDA as their primary public sector collaborators. FMOH and its implementing agencies were viewed as the custodians and drivers of the UHC by 2030 goal in the country and considered integral in executing UHC-related activities. Areas of collaboration have centered on improving PHC through implementation of the Primary Healthcare Revitalization Initiative, PHCOUR, the NHIS and advocacy on allocating at least 1% of the consolidated revenue as the BHCPF as provided by the National Health Act and attainment of the 2001 Abuja Declaration

Public sector respondents, on the other hand, cited the development partners, donors and civil society as key collaborators. Some CSOs and development partners mentioned emerging collaboration with national and state legislators. Also, some CSOs mentioned collaboration with professional associations, medical interest groups and individual activists.

### **Stakeholders Not Currently Engaged**

Though no consistent group emerged as "excluded" from the engagement around UHC, examples of those identified as "left out" include the private sector and other key MDAs such as Federal Ministry of Finance, Ministry of Budget and National Planning and Ministry of Education. Other groups of respondents felt more collaboration would be beneficial if conducted with research institutions, media, local government, organized unions, and public finance departments.

As described by one of the respondents –“the key government stakeholders needed in the discussion on UHC include Federal Ministry of Health, Federal Ministry of Finance, Ministry of Budget and National Planning and their equivalents at the state level.” Inter-ministerial collaboration was also cited as an area that could be further strengthened. One respondent discussed the inclusion of the Ministry of Education in deliberations on training facilities and accreditation. The Water and Agriculture Ministry was suggested for inclusion in training and accreditation.

Generally, some CSOs and private sector respondents stated that the FMOH needs stronger engagement with other stakeholders: one respondent expressed that the FMOH had not interacted very well in the past in engaging stakeholders, particularly in the finance sector. Deeper engagement with local governments, particularly on operating PHC facilities, was also mentioned as important to mobilize the capacity needed to operate effectively.

One solution proffered was a detailed mapping by the MOH to better understand stakeholders’ interests and areas of work related to UHC. Two respondents indicated they are currently working on this at national and state levels although FMOH had already mapped about 30+ different groups as UHC partners.

Though the private sector was viewed as a partner, respondents also identified the desire to further engage them. However, the nature of such proposed engagement varied. One suggestion was engagement with HMOs and private insurance. Though the private sector is already engaged through the private sector alliance, another respondent suggested that their participation and contribution to the UHC dialogue could improve. Another view was for the private sector to share their innovative mechanisms so that others can learn from these innovations to improve their effectiveness and efficiency. In addition, it was proposed that the private sector could play a bigger role in administering federal medical centers and tertiary institutions. Finally, another approach was to tap into the wider private sector for funding through corporate social responsibility. One constraint cited was weak mechanisms for engaging with them, comparative to public sector mechanisms through FMOH and NHIS.

Other groups identified as potential partners were the media as well as the National Human Rights Commission and the National Orientation Agency; research institutions; organized unions, e.g. Nigerian Union of Local Government Employees and Nigerian Labor Congress; consumers and community representatives. Also mentioned were marginalized populations such as people with disabilities and special needs groups.

### **Fostering Collaboration Among Diverse Groups**

There were varied responses from stakeholders on fostering collaboration among diverse groups. However, some respondents’ suggestion was to expand existing platforms to mobilize all stakeholders and diverse groups to be on board, though funding was cited as a possible issue for continuance and commitment. Respondents encouraged virtual platform usage and cited the JLN network as a platform that could be expanded to foster collaboration.

#### **○ Country Level Stakeholder Platforms**

Various platforms exist within the country and among different stakeholder categories. The majority of these are either sector-based or internal, where specific organizations, coalitions or alliances organize, set the agenda and invite stakeholders.

Emerging as the key platform for UHC dialogue is the National Council on Health (NCH) review meeting – an annual, cross-sectoral meeting convened by the FMOH to review progress on health policy implementation, and to develop plans and programs aimed at improving health indices for the subsequent

year. Participation, as described by respondents, is wide and inclusive, encompassing other relevant federal MDAs (such as MOF, MBNP, and MOE), private sector (including indigenous pharmaceutical companies), CSOs, development partners and donors. Similarly, various states convene state council on health review meetings.

Commenting on the effectiveness of the NCH platform, stakeholders highlighted that despite the broad and inclusive constitution and participation by key policy and decision makers from all sectors, there was lack of effectiveness for two reasons: implementation of resolutions was weak at all levels, and the frequency of the annual meeting made it difficult to follow up on progress.

Another platform for UHC dialogue cited by respondents was the Healthcare Finance and Investment Technical Working Group (HCF&ITWG). The platform was observed as a key driver of the development of the National Health Financing Policy and Strategy recently adopted at the November 2017 National Council on Health. The TWG was composed of key government MDAs (FMOH, NPHCDA, NHIS), all development partners engaged in UHC (WHO, UNFPA, WB, USAID, BMGF, DFID, SIDA, WB, UNICEF), CSOs, private sector, technocrats and academia, in other words, a very broad-based participation. The TWG met on a quarterly basis with a very articulate agenda on health financing and addressed emerging issues. However, the minister of health disbanded the TWG in 2016 with a promise to reconstitute it, but this has not taken place.

The Health Sector Reform Coalition (HSRC) is another existing platform for UHC engagements. The Health Reform Foundation of Nigeria (HERFON), a national NGO, which represents the CSOs on the national and regional platforms of the Global Financing Facility, facilitates the HSRC. The HSRC is a loose coalition of over 50 members made up of civil society and professional organizations, public and private sector officers, development partners, academia and the media. The HSRC championed the passage of the National Health Act.

Another emerging platform for UHC dialogue mentioned by respondents is the Legislative Advocacy Network launched in 2017 at the national level. A development partner, USAID-funded Health Finance and Governance (HFG) project, is currently supporting the forum. The national legislators commit to replicate the network in all 36 states. The legislative network at national and state levels will deploy appropriation, legislation, oversight and accountability to advance UHC.

Other reported sector-specific platforms not particularly on UHC but contributing to related dialogues mentioned by stakeholders included Citizens Wealth Platform, Private Sector Health Alliance of Nigeria and the Nigeria Governors Forum.

Almost all stakeholder respondents indicated considerable level of awareness and engagement with platforms facilitating UHC activities and dialogue in the country. Respondents indicated civil society, development partners and the federal ministry of health as front-runners in facilitating these platforms. All the stakeholder groups noted various levels of their participation in different platforms and expressed different opinions on their effectiveness, citing reasons such as lack of quality leadership, inconsistency in agenda, frequent meetings and lack of resources to convene large meetings for important issues.

### **Collaboration With Regional Entities On UHC**

The public sector, implementing partners and CSOs mentioned that collaboration with regional entities such as ECOWAS, WAHO, WHO, African Christian Health Association, towards advancing UHC focused on knowledge sharing and learning. Other examples cited by CSOs, professional groups and faith-based organizations included participation in global think tanks for PHC.

Overall, respondents reported the role of regional organizations in advancing UHC as advisory to member-states to implement resolutions and commitments; supporting in-country activities, e.g. mapping for UHC 2030; addressing cross-border pandemics such as the Ebola outbreak and outlook for health outcomes. However, respondents, especially the CSOs, private sector and implementing partners, stated that regional organizations could play a more significant role in progressing UHC in the country through funding and increased education and enlightenment of the UHC concept.

## 2.3 BARRIERS AND CHALLENGES RELATED TO UHC

### ○ Political Economy Barriers

There are three political economy issues that were identified as key barriers towards UHC progress in Nigeria. A majority of the respondents felt that poor governance was the most significant political economy barrier to advancing UHC in Nigeria. At least one respondent from the CSO, politician implementing partner, private implementer, researcher and technician stakeholder groups, cited inadequate political will, commitment, and support to advance UHC. There was concern that laws have been promulgated and commitments made towards UHC but the actual implementation is slow. An example cited by a respondent in the implementing partner stakeholder group, which also resonated with other stakeholders generally was that, beyond the presidential declaration on UHC in 2014 and signing of the National Health Act, which provides for BHCPF, there has been lack of strong commitment from the government to allocate at least 1% of the consolidated revenue required to establish the fund which is additional funding for PHC. Respondents also mentioned that mismanagement and a lack of clarity of the roles of the different levels of government with regards to health care financing, as well as clarity around which components were to be financed by each level, delayed progress towards UHC.

It also emerged that the lack of common approach for UHC in Nigeria was a significant political economy barrier. Respondents across different stakeholder groups, including CSO, politician, implementing partner, researcher and technician stakeholders, cited the most common barrier as limited coordination of UHC initiatives due to divergent donor interests as well as funding pots for UHC, and a focus on the federal level at the expense of the states.

Corruption also emerged as a political economy barrier for UHC in Nigeria, with at least one respondent in the CSO, public implementer, politician and private implementer stakeholder groups explicitly citing it.

### ○ Funding Issues:

Funding was cited by respondents across different stakeholder groups as a key barrier to advancing UHC.

#### **Box 3: Barriers and Challenges for UHC – Political Economy Barriers**

*“Governance structures misaligned with the UHC agenda and the constant changes in government. It takes resources to realign and get people on the same page again after a change in administration.” – Private Implementer*

*“Political will – laws are signed and commitments made, but actual actions don’t follow through, for example, on the allocation for healthcare.” – Implementing Partner*

*“Different actors have their own initiatives, which are donor driven - collective agenda and collective action are still limited/ missing.” – Implementing Partner*

*“People have good intentions for trying to push the agenda forward, but corruption is one area that needs to be taken more seriously as it is everywhere. That discourages anyone from thinking ahead” – Politician*

The issue of funding is multifaceted. Some of the respondents in the CSO and politician stakeholder groups specifically pointed to the low budgetary allocation for health in Nigeria, at less than 6%, as a significant challenge for attaining UHC. In addition, some respondents specifically pointed to even lower funding for health at sub-national levels. One implementing partner respondent cited that in addition to being underfunded, there's a fiscal space challenge at the state level, where states experience difficulties in determining how they can achieve more results with the limited resources available for health. Another CSO respondent mentioned poor funding at the local government level as a great barrier for UHC.

Besides allocation, there is the issue of late and inadequate release of allocated funds both at national and sub-national levels. Some respondents indicated that a few sub-national governments in the last two years allocated 15% of their health budgets, but released less than 10%.

Misallocation and inefficient utilization of allocated funds were mentioned as related barriers. A CSO respondent further cited funding allocation in the national budget as being skewed in favor of secondary and tertiary care as opposed to primary health care where the disease burden is greater.

#### **Box 4: Barriers and Challenges for UHC – Funding Issues**

*“Funding – the way allocations are done, doesn't address how to mobilize resources.” – Implementing Partner*

*“Local governments have to be critical – but are poorly funded and this is a great barrier for UHC as they can potentially serve as a better gateway for UHC. Lower level of the system needs to be funded and given the rightful place in terms of policy.” – CSO*

*“Part of the problem is the financing of health system – there's inverted funding to where the health crisis really is, for example where tertiary health structures get higher funding than secondary and primary health structures when the larger disease burden is at the primary health care level.” – CSO*

#### ○ Limited understanding of UHC:

Some stakeholder groups cited the limited understanding of UHC at different levels as a barrier to advancing UHC in Nigeria. Respondents pointed to a general lack of awareness about UHC by citizens as well as key players and decision makers, including civil servants at state and local government levels, funders, policy makers and private sector. A majority of consumers are unaware of available services and their rights, while individuals responsible for driving UHC lack clarity around UHC resulting in poor governance around UHC and “no champions”. As one respondent put it, “if you don't know what you're entitled to, you don't know what to ask for.”

#### **Box 5: Barriers and Challenges for UHC – Limited Understanding of UHC**

*“Many decisions are taken at the political level. If someone does not understand and appreciate the facets to UHC it will lead to many problems.” – Technician*

*“Even civil servants at state and local government levels who should have some knowledge, lack knowledge of what UHC is” – CSO*

*“Champions are needed to drive UHC at both federal government and state levels. Most states are clueless about what UHC is all about – meaning there's lack of knowledge at the state level and this knowledge needs to be created.” – Researcher*

- Weak health systems and service delivery

Some respondents also felt that weak health systems and service delivery area barrier to achieving UHC in Nigeria. These include the inadequate and poorly distributed human resources for health, weak referral systems and insufficient commodities and infrastructure. Inadequate health facilities/infrastructure, poor procurement and drug management systems leading to a shortage of essential drugs and supplies, highly regressive out-of-pocket expenditure, and inadequate mechanisms for access to care (almost zero referral system) were some factors that respondents identified as affecting overall performance of the health care system and thus progress towards UHC.

**Box 6: Barriers and Challenges for UHC – Weak Health Systems and Service Delivery**

*“In health systems, health financing and governance are the bedrock because to determine service delivery, HRH, MIS, pharmaceuticals, good financing and governance are required. If foundation of health financing is weak, all other complementary systems are weak.” – Private Implementer*

### 2.3 PERCEPTION OF KEY POLICIES AND STRATEGIES

Stakeholders identified various policies and plans that the Nigerian government had put in place that support UHC and relate to equitable access to quality healthcare. At the federal level, these include National Health Act 2014, which establishes the Basic Health Care Provision Fund; the National Health Policy 2016; National Health Insurance Scheme Act 2009, National Strategic Health Development Plan; Bringing PHC Under One Roof 2011; Saving One Million Lives Initiative - Program For Results; and most recently, the Nigeria Health Financing Policy and Strategy 2017.

Stakeholders pointed out that very few of these policy frameworks have been adapted at the state level. However, there are ongoing efforts by the FMOH and its implementing agencies, some development partners, and CSOs to work with states to adapt and implement policies such as the NHIS, PHCOUR and the Health Act.

Implementation of UHC-related policies and strategies was generally thought to be slow with very few policies being translated to action. At the last 2017 National Council on Health, the status of implementation of resolutions and domestication of policies at federal and state levels scored 3%. Moreover, the enacted National Health Act has not automatically resulted in its implementation three years down the line.

In addition to lack of political will, poor governance structures and funding, most of the respondents pointed to the slow implementation due to challenges with implementation, with one respondent further pointing out challenges with policy design whereby theory of change of the policy (how the change/results targeted will be achieved) is not articulated nor critiqued. The respondent put it this way: *“The issue isn’t the lack of policies, it is implementation. No more laws are needed. Focus on 100% implementation first.”*

### **Box 7: Key Policies and Strategies**

*“National health financing policy and strategy is in place - if well implemented, including BHCPF, it can lead to achieving UHC.” – **Implementing Partner***

*“The most important legislation is the National Health Act of 2014, but very little has been done towards its implementation, three years after it was passed.” – **CSO***

*“Policy development is very different from policy implementation in Nigeria. For instance, the National Health Act when enacted did not automatically result in its implementation, 3 years down the line.” – **Implementing Partner***

*“Implementation is a major problem - there are a lot of lessons being learned including even outside the health sector - on how things can be done differently, the challenge is both with policy design and the implementation.” – **Implementing Partner***

#### ○ Inclusive design process

There were mixed responses as to whether respondents felt that policy makers and implementers took the stakeholders’ views into account when designing and implementing UHC-related policies. Some stakeholders were deeply involved in the process, with one CSO respondent providing evidence/data towards the FMOH’s Medium Term Sector Strategy and also a “clause-by-clause analysis” of the amendments to the National Health Insurance Strategy. Some stakeholders further pointed to public hearings, where community members are able to participate in the policy-making process, but one respondent noted that not all policies usually incorporate public hearings during their design phase. Some stakeholders expressed that there was a need for more effective engagement of community members, civil society and other non-state actors in UHC related activities at both policy and implementation phases. They also cited a need to build the capacity of implementers to better understand policies and strategies, if they were to effectively implement them.

It was unclear the extent to which stakeholders felt that evidence were used in decision making, but various types of information was contributed by different respondents to aid in decision-making. This included data and evidence on key health indicators, health sector and bill analysis and information on organizations’ contribution to the health sector.

#### ○ Perceptions of country-level solutions and innovations

Government policies and strategies that were considered innovative and supported progress towards UHC included Primary Health Care Under One Roof (PHCUOR), Basic Healthcare Provision Fund (BHCPF), National Health Insurance Scheme and the Basket Fund to finance primary health care.

Other innovations that stakeholders identified were:

- Drug Revolving Fund (DRF) -a strategy to ensure an uninterrupted drug supply at primary health care facilities. Revenue generated from the sale of drugs to patients is used to purchase new drugs and ensure availability.
- Impact Bond for Health, where the bond is focused on a particular health outcome, e.g. malaria, and benchmarks are set against which investments would be made. Private money is then put towards achieving this and investors reap their investment once the result is achieved (not fully implemented due to failed health market).

- Development of an adoption tree to help private sector, especially philanthropists in Nigeria, to adopt the very poor and help them pre-pay for healthcare (premiums and insurance), thus increasing prepayment coverage of the huge informal sector (advanced but has not been fully implemented).
- Nigerian Health Watch and Nigeria Healthcare Foundation, which are organizations that provide information around topical health issues at state level; for example, which states are passing on new legislation in healthcare financing like Kano or Kaduna.
- The Health Communication Capacity Collaborative project (HC3), a global USAID-funded project that is designed to strengthen developing country capacity to implement state-of-the-art social and behavior change communication programs. In Nigeria, they have tried to pilot the roles of traditional rulers as an advocacy group in the community for uptake of services. Within six months, uptake of family planning services increased in the three states including Bauchi.

Stakeholder made the following recommendations to accelerate progress towards UHC:

- A significant number of stakeholders recommended the need for more involvement of local, state and community players in order to accelerate progress towards achieving UHC. Increased community engagement and participation in policy formulation and implementation was suggested. This would involve empowering communities to understand their rights; providing community and local leadership access to information; improving community involvement in policy and decision making forums; enhancing their ability to demand accountability; and developing their capacity to work with the government and other stakeholders through community-based organizations, CSOs and village development committees. One respondent specifically cited that communities should be involved in managing health facilities through CBOs. Some respondents also mentioned the need for deeper involvement of states and state-level sensitization on UHC, so that they can better understand the need to pay for health.
- Some stakeholders, and CSOs in particular, pointed towards more involvement of CSOs as a good step towards attaining UHC, due to the role that CSOs play in promoting accountability and community mobilization, which are both important to move UHC forward. The role of CSOs in monitoring and demanding accountability on health commitments, in line with the government's priorities, remains important for moving UHC forward.
- A few stakeholders further mentioned that strengthening primary care is necessary to reach the UHC goal for Nigeria. One respondent cited that PHC should be prioritized, with the core goals of increasing physical and financial access to quality healthcare. Two other recommendations in relation to PHC were made regarding developing BHCPF guidelines for the states, since this fund would go towards PHC and health insurance schemes, and defining a budget and channeling resources towards PHCDA at the state level to increase health coverage.
- Some respondents also mentioned advantage of ICT/technology innovation to advance UHC and felt that ICT has the potential of expanding coverage of insurance and increasing accountability. Automating the health insurance system at each level could facilitate enrollment and also provide visibility to work of health maintenance organizations. One respondent cited ICT for UHC as an initiative that could potentially help in identifying the informal sector, enrolling them, collecting premiums and also collecting their feedback.

### **Box 8: Country Level Solutions**

*“Involve communities in the management (through CBOs) of community-owned institutions/ facilities at local level and driving policy at that level” – CSO*

*“Because of the design of the healthcare system, UHC can’t happen without getting the states to work – they need to understand and commit to implementation.” – Implementing Partner*

*“CSOs need to innovate around demand generation. The innovations CSOs have been deploying, the use of traditional rulers and religious leaders to be the mouth organs of the communities has been effective.” – Implementing Partner*

*“CSOs require multi-year funding to stay on course; long-term, predictable financing.” - CSO*  
*“ICT provides a lot of potential in terms of identifying the informal sector, innovative ways of collection g premiums and engaging them and collecting feedback from them” – Implementing Partner*

### ○ **Perceptions of regional level innovations**

Innovations in African region (outside Nigeria) that stakeholders mentioned included, Ghana’s Social Health Insurance System and its introduction of a 2% surcharge on all imports to fund basic healthcare. Johannesburg General Hospital in South Africa was cited by one respondent as a good model of public and private sector collaboration and a potential model that the Nigerian health public sector could refer to in terms of engaging with the private health sector to improve service delivery in public health facilities.

### **3. ACS APPROACH**

The ACS approach focuses on finding synergies with existing UHC and health financing initiatives to amplify them by working on a demand-driven basis to build skills in accountability, collaboration, and shared knowledge and learning thus driving progress in UHC. To validate the approach, stakeholders were asked about their perceptions of the three specific areas ACS could potentially support.

Increased collaboration, particularly helping to bring multiple actors together— i.e. state, communities, private sector and NGOs — was the most suggested area for support. Developing a country-wide UHC plan, providing technical assistance in UHC-related technical areas, knowledge sharing, and generating data/evidence were also mentioned as additional support areas, which could play a role in either ensuring accountability to UHC commitments or in assisting with the highlighted challenge of creating political will.

The three components of accountability, collaboration and knowledge sharing are further discussed below.

#### **Accountability**

None of the stakeholders interviewed felt that the country actors, especially governments, are being held sufficiently accountable for commitments made towards attaining UHC. This was best highlighted by one of the respondents that pointed out that, as the first level of accountability, the National Health Act stipulates that the state of health be presented annually to the president and the people of Nigeria. However, this has not taken place since the enactment of the National Health Act in 2014.

Stakeholders from various groups including development partners, implementing partners, technicians, and civil society noted that CSOs have played a key role in pushing for accountability on progress made towards UHC in Nigeria. This includes putting the government to task around the appropriation and release of the 1% consolidated revenue fund (CRF) of the federal government revenue towards the BHCPF. However, civil society's accountability role has faced several challenges, including lack of sufficient funding. In addition, they can only act as whistleblowers, and lack legal authority to enforce accountability.

Despite a reportedly poor outlook on accountability, stakeholders were hopeful that the culture of accountability could be improved by implementing a few key strategies in Nigeria. The common suggestions included developing or improving on frameworks/tools and systems for accountability, increasing participation and commitment of all relevant stakeholders (but more specifically the community by making them aware of their rights to health) and establishing common definitions and increased understanding of UHC. Many noted a need to track flow of funds (budget transparency), and strengthening of civil society's voice while fostering their independence (including through consistent sources of funding), to allow them to continue playing a role in enforcing accountability around UHC commitments.

The key activities that stakeholders indicated ACS could undertake to support accountability revolved around three key areas:

- Support activities around legislative and policy advocacy, including strengthening non-state actors' voices to hold state actors to account.
- Support development/creation of systems that would strengthen governance. This includes a functional monitoring and evaluation system, and financial systems that would enable budget tracking and timely release of funds.

***Box 9: Accountability***

*“Accountability entails not just what you’ve done but also how efficiently allocated resources have been used”. – Civil Society*

*“CSOs try to hold Government accountable, but just act as whistleblowers with no legal power to arrest violator”. – Development Partner*

*“Knowledge of average Nigerians needs to be upgraded to know their rights and hold leadership accountable”. – Public Implementer Partner*

- Help generate/disseminate data and evidence-based knowledge to create a continuous value proposition for health investments and UHC.

**Collaboration**

Many respondents acknowledged a lack of broad stakeholder involvement in the conversations to catalyze progress towards UHC. Challenges to collaboration and involvement of all stakeholders included organizational and logistical difficulties, and limited frameworks and processes to effectively engage all stakeholders. The most excluded stakeholders mentioned in descending order are civil society, local leaders, private sector, community, government, NGOS, news media, and technicians.

**Box 10: Collaboration/Inclusion of stakeholders**

“Projects that have engaged multiple stakeholders to move forward may not move very quickly but when they move they get a lot of support, but programs or projects that start unilaterally may move fast but usually have a lot of issues moving forward.” -**Implementing partner**

“If the state is engaged in its design, that would be awesome. Most times projects are developed through the federal approach without engaging the states meaningfully and they do not do well” –**Implementing partner**

There was general agreement that involving a broader range of stakeholders could catalyze progress towards UHC. One reason given for this was that effective solutions to existing health challenges could more likely be reached through collaborative efforts by both health and non-health stakeholders. In addition, an implementing partner emphasized that despite the slow start of projects that utilize an all-inclusive approach, such projects are usually the most successful once they gain momentum. The importance of involving state-level stakeholders from the beginning, for successful implementation of state-level implemented projects, was also underscored by respondents from political, technician, implementing partner and civil society stakeholder groups.

The main activity that stakeholders indicated ACS could undertake to support increased collaboration is supporting already existing platforms/structures that would allow key stakeholder groups that are currently not interacting to interact. This included strengthening the links between CSOs and the private sector with a view to enabling the private sector to be more integral to the health system. The community was another group that stakeholders felt ACS could play a key role in supporting towards increased engagement and participation. Stakeholders emphasized the need for ACS to keep government at the fore of discussions and agreements and to keep the project aligned with Nigeria’s priorities towards UHC. Co-writing and disseminating research papers on UHC was another activity that was mentioned that could promote collaboration.

**Learning and Knowledge Sharing**

A few stakeholders agreed that there was some culture around knowledge sharing and learning in Nigeria. However, most spoke of sharing knowledge rather than learning and indicated that the culture of both could be improved. The Joint Learning Network was cited as a useful learning/sharing platform. In addition, the Nigerian Health Watch and Healthcare Foundation of Nigeria were provided as examples of online platforms that provide quality and timely health sector-related information. An atypical method of knowledge sharing mentioned was by the legislative network, where legislators use WhatsApp groups to discuss challenges and learn from their counterparts. Other stakeholders use conferences as learning occasions as well as platforms to showcase their work. Seconding technical experts to under-served public offices was also seen as offering opportunities for learning and knowledge transfer.

General reasons given for inadequate sharing of knowledge and learning in Nigeria are limited resources and a lack of formal processes for sharing and learning. A technician stakeholder also emphasized the need for more effort towards operationalization or implementation of acquired knowledge, as focusing only on knowledge acquisition is insufficient. The acquired knowledge should generate practical results. Additional challenges included, closed access to some of the existing platforms for learning and sharing, particularly those exclusively for professionals; and limited culture of use of evidence for public health decision making. The involvement of key sub-national level stakeholders such as those in state governments, and avoidance of taking a “siloed” approach, was once again offered as a solution by respondents- this time as a way to improve functional learning and knowledge sharing platforms for UHC.

An additional recommendation around improving the knowledge sharing and learning culture for UHC was organizing dialogue with political aspirants and political parties around UHC, and if possible influencing them to include UHC in their manifestos. This way, politicians would be educated about UHC prior to holding political offices. Better coordinated technology platforms were also offered as a solution to supporting learning and knowledge sharing, as well as improvement in access to information and data as a way to inform improved design and implementation of health interventions and to channel resources more strategically. There is also a need to promote cooperative learning amongst states and stave off the competitive culture that does not promote cross-state learning. A respondent noted that learning should be adapted to what is feasible in the Nigerian context.

#### **Box 11: Knowledge Sharing**

“We are in the computer era. Let us have access to data and information. Why can’t there be free access to information for people who want to intervene.”- **Public Implementer**

“When you acquire knowledge and put it into practice, then it will cascade and foster the culture of learning and knowledge sharing.” – **Technician**

The key activities that stakeholders indicated ACS could undertake to support shared knowledge and learning focused on capacity building and sharing of knowledge and best practices. Embedding technical experts in government was provided as a good option for building capacity in the public sector. Key activities are highlighted below:

- Capacity building: Help build knowledge to support governments around innovative and sustainable financing and financing for UHC and provide technical support for health financing reforms with a focus on developing costed UHC plans; support evidence generation and dissemination for UHC; leadership training with a focus on advocacy and monitoring and evaluation skills.
- Sharing of knowledge and best practices: Identify and share innovations across states; cascade UHC policy frameworks and understanding from national to sub-national governments and community-level organizations.

## **POTENTIAL CHALLENGES TO THE ACS PROJECT**

Stakeholders identified several challenges that could impede the successful implementation of the ACS project and provided suggested solutions. If the challenges are addressed, ACS may be in an improved position to achieve successful outcomes. The challenges most mentioned included:

**Demonstrating differentiated value as project and not re-inventing the wheel:** A few stakeholders stressed that since there are already very many partners in health financing and UHC, the ACS project would need to acknowledge existing efforts from other partners and get them to appreciate the value

that the project would bring by focusing on filling in the gaps. As one respondent put it, ACS would need to “*carve own part of the cake and work harmoniously with others*”.

**Resistance from organizations that are already working in the UHC space:** Some stakeholders felt that the partners who are already working in the health financing and UHC space might see the ACS project as competition. Proper mapping of stakeholders, their level of influence, how best to engage them and the incentives to keep them engaged, is needed. Respondents recommended that ACS should adopt an open and transparent strategy to allay fears around the project and also clarify the roles of different stakeholders in the UHC platforms it will support, with the government playing a leading role, to avoid partisanship and undue external influence.

**Limited political will and buy in to support the ACS agenda:** A key potential challenge that was identified is the political economy of Nigeria and its diverse context and culture with only a few champions who are willing to move the UHC agenda forward. Political engagement, both at the federal and state levels was thought to be a difficult but necessary part of the process, to ensure success of the project.

Meeting the project’s targets was highlighted as a risk as it was perceived that it may be difficult if the pace of key partners (such as government) is slow. However, stakeholders still recommend full inclusion of all relevant stakeholders, with the government taking the lead. A further suggestion was given of embedding staff within government structure as this would reinforce capacity and sustain efforts while not impoverishing the system by taking key limited resources away from the public sector for the ACS project.

	<b>2014</b>
Nominal GDP (Billions)	90,137
Population (Thousands)	177476
Population (Millions)	177
Total Health Expenditure (THE, Billions)	3,040
GGHE/THE (%)	12.7
THE/GDP (%)	3.5
GGHE/GGE (%)	4.5
Federal	5.7
State	4.1
Local	2.7
External/THE (%)	13.0
Per-capita THE (NGN)	17,812
Per-capita THE (US\$)	112.3
OOP/THE (%)	68.6
Social Health Insurance/THE	1.7
Hospital/THE	32.9
Prevention/THE	16.5

## ANNEX 2

<b>Respondent Profile</b>			
<b>Stakeholder Category</b>	<b>Total #</b>	<b>Gender</b>	
		<b>Male</b>	<b>Female</b>
<b>National</b>			
Civil Society Organizations	5	4	1
Development/Implementing Partner	5	4	1
Politician	3	3	0
Private Implementer/Technician	4	4	0
Public Implementer/Technician	5	3	2
Researcher	1	1	
Individual Activist	2	1	1
<b>Total</b>	<b>25</b>	<b>20</b>	<b>5</b>
<b>Sub National ( Bauchi State)</b>			
Civil Society Organizations	1		1
Politician	1	1	
Private Implementer	1	1	
Public Implementer	2	1	1
<b>Total</b>	<b>5</b>	<b>3</b>	<b>2</b>

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